Case 21-3168

APPLICATION FOR BENEFITS
SEX CRIME VICTIM SERVICES FUND

State Form 241 (R11 / 5-19)

encore

INSTRUCTIONS:
1. *Remove the information sheet and prescription identification card. Give both to the patient and ask them to read it prior to completing the application for benefits.*
2. *Attach a copy of the patient's complete Emergency Room record from the date of examination.*
3. *Attach an itemized bill to this application.*

SAK Serial Number: IN21-11685

If you have questions or concerns, please contact the Indiana Criminal Justice Institute at 317-232-1233.

Send **ORIGINAL WHITE** copy to: Indiana Criminal Justice Institute, 101 W. Washington St. Suite 1170 - East Tower, Indianapolis, IN 46204.

A. Consent (*To be completed by patient or guardian.*) *Initial by each item to indicate consent and understanding.*

_____ 1. I have read and understand the attached letter explaining the sex crime victim services fund.

_____ 2. I authorize this facility, its physicians, agents, and employees to examine me in relation to an alleged sexual assault, and to conduct tests for that purpose.

_____ 3. I authorize this hospital to release a completed copy of this application/report with any evidence of sexual assault , including, but not limited to, my clothing, laboratory specimens and medical records of this date to *(law enforcement agency)*: IU University police

_____ 4. I authorize the release of this application and medical records of this date to the sex crime victim services fund for the purpose of evaluation and payment.

NA 5. If this case involves a minor, I authorize the appropriate Child Protective Services caseworker or law enforcement to release information regarding this investigation to the Indiana Criminal Justice Institute.

Signature of patient or guardian	If patient is a minor, relationship to signee	Date *(mm/dd/yyyy)*
[redacted]	NA	10/13/2021

B. Identifying Information (*To be completed by hospital personnel.*)

Is the patient a minor? If patient is seventeen (17) or under, you must report to law enforcement or Child Protective Services. *(check)* ☐ Yes ☒ No

Name of patient	Name of parent or guardian *(if patient is a minor)*
[redacted]	NA

Gender *(check)*	Race of Patient*	Marital Status	Date of birth *(mm/dd/yyyy)*	Date of assault / abuse *(mm/dd/yyyy)*
☐ Male ☒ Female	[redacted]	Single	[redacted]	10/13/2021

Address *(Street, City, State, ZIP Code)*: [redacted]

C. Information about the assault (*To be completed by hospital personnel.*)

Is the patient reporting to law enforcement?** *(check)* ☐ Yes ☒ No

If reported, date reported to law enforcement *(mm/dd/yyyy)*	Exact location of assault *(If known, address, city, state, county)*
NA /	Unknown

Name of agency notified	Name of officer / case worker reporting
NA	NA

Case Number Assigned	Approximate time assault occurred	Date arrived at hospital *(mm/dd/yyyy)*	Date evidence collected *(mm/dd/yyyy)*
NA	: ☐ AM ☐ PM	10/13/2021	10/13/2021

Suspect's Name *(if known / applicable)*	Relationship to patient / victim *(if applicable)*
NA	Unknown

Does patient / victim know the suspect(s)? *(check)*	Race of Suspect *(if known)**
NA ☐ Yes ☒ No	NA Unknown

Type of sexual trauma *(check all that apply)*:	Type of evidence collected *(check all that apply)*:
☐ Vaginal ☐ Child Molestation *(under sixteen (16))* ☐ Oral ☐ Anal	☒ Sexual Assault (SA) Kit ☐ Clothing ☒ Medical Forensic Examination
☒ Unknown ☐ Other *(specify)*:	☐ Patient History ☐ Other *(specify)*:

Was the collected evidence transferred to law enforcement? *(check)*	Date of evidence transfer to law enforcement *(mm/dd/yyyy)*
☒ Yes ☐ No	10/13/2021

Name of transporting officer	Badge Identification number
Mark Morris	38

Signature of transporting officer: [redacted]

D. Service Provider information (*To be completed by hospital personnel.*)

Patient Account Number	Was the patient admitted for inpatient care? *(check)*
[redacted]	☐ Yes ☒ No

Was the patient transferred from another facility? *(check)*	Name of transferring facility
☐ Yes ☒ No	NA

Name of provider performing the exam	Telephone
Melanie Hamilton	(812) 353-9515

Signature of provider	E-mail
[redacted]	

*Included for research purposes only. **Reporting is mandatory for all children ages seventeen (17) and younger.

DISTRIBUTION: Instruction Page – Patient; White – ICJI; Canary – Law Enforcement Agency; Pink - Hospital